Bidder Questions and Answers – 3:

1. What is the State's vision of the scope of responsibilities of the physician providers who agree to serve as a PCP for enrolled clients?

PCPs will act as the medical home for the clients enrolled in the DM program, and will coordinate with the DM case manager to ensure clients receive needed medical care.

2. In the Healthy Options program, what is the usual and customary fee paid to PCPs for their services? Or stated in a different way, what level of reimbursement would the State consider as "usual and customary" for the PCP services provided by the fee for service physicians who agree to do so for enrolled clients?

The providers who serve the clients in the DM program will be paid fee for service for the medical services they provide. DM contractors will be free to negotiate with PCPs for a case management fee for the clients they serve.

3. In Section III, Funding, Part B, you discuss default versus voluntary assignment. Please define those terms?

In a voluntary situation, clients would participate in the DM program only by making the choice to enroll in the program – MAA would make no involuntary assignments. Default enrollment is the term MAA is using to define the process whereby MAA would assign clients to the DM program rather than relying on voluntary enrollment. Clients would have the option of calling MAA to disenroll from the program (Opt-out).

4. In Section III, Funding, last paragraph, you address contractors being required to bear one-half of the cost of an external evaluation. Knowing that there could be multiple vendors, and that the share of the evaluation borne by a vendor will be proportionate to the share of DM clients it services, which is currently unknown, can you provide any further information that might help us determine what total cost is likely to be?

How will cost for external evaluation be divided among contractors, (ie, number of enrolled units, percentage of overall contract, etc.). What if participants utilize more than one service?

At this point, it is hard to determine the exact cost to be borne by each of the three contractors. The cost assigned to each contractor will be determined by the number of enrollees projected in each program. We will not have this information until contractors are selected. Bidders should submit their best estimate based on the number of clients in the bidder's proposal.

Each enrollee will participate with only one program; either the statewide project or a local project. MAA will pay the contractor a case management fee for each enrollee, and will pay for medical costs separately.

5. In Section IV, Contract Awards, please describe how the projects in part A and part B will differ.

Part A refers to statewide projects serving adults with multiple medical conditions.

Part B refers to local projects: B.1. would serve adults with multiple medical conditions, and B.2. would serve children with one or more conditions.

Additionally we hope that each of the three funded projects will have a different focus.

6. In Section IV, Contract Awards, what is "GA-U"?

GA-U refers to a State funded program called "General Assistance – Unemployable". Clients served by this program have medical and/or mental health conditions that lack the severity of SSI eligible clients, but still renders the client unable to function in the workplace.

7. In Section IV, Contract Awards, you describe three contracts, one in part A and two in part B. Can contractors bid on all three if they are capable and desire to do so?

We can accept only one bid per bidder.

8. If a vendor does not currently have a Washington Uniform Business Identification (UBI) number, but will register if the work is awarded, can it still bid on this project?

9. Yes, but the successful bidder(s) would need to have a current UBI number prior to the execution of the contract.

10. Will you consider a single disease program that manages the entire care spectrum for a patient with a specific disease for the statewide program?

A bidder may submit a proposal that focuses on clients who have one particular disease, if the proposal clearly indicates the inclusion of coordination of care for co-morbid conditions. MAA will not entertain RFP responses that are limited to management of a single disease, because MAA FFS clients have multiple co-morbidities that must be considered in order to decrease overall costs and manage their care more effectively.

11. Can DSHS provide any assistance in notifying the DM company about hospital admissions when they occur (i.e. is MAA notified)?

Often MAA finds out about a hospital admission when the claims are submitted – it could be months later. One goal of contracting for the disease management projects is to get the clients coordinated enough care that the DM contractor is aware of the admission prior to MAA receiving a claim.

12. Are both FFS and Healthy Options patients eligible for the DM program?

No. Only FFS clients will be enrolled in the DM program.

13. Can DSHS provide monthly claims data for DM Program participants?

Yes. In general, 80% of claims are submitted within 4 months of the date of service; however, there is sometimes a substantial delay in the claims data, because providers have 365 dates to submit their claims.

14. Please provide details on MAA's transportation benefit.

MAA contracts 9 transportation brokers, holding contracts for 13 transportation regions. These brokers are responsible for arranging non-emergency transportation for Medicaid clients to any covered medical appointment. Methods of transportation include: Cabulance, taxi, bus passes, gasoline vouchers and volunteer drivers.

15. Will DSHS consider a specialist physician to be the primary care provider?

Yes, DSHS will consider specialist PCPs on a case-by-case basis.

16. Since the detailed data analysis will take about 2 weeks, can you provide the following information: Prevalence of CHF, CAD and Diabetes. Co-morbidity overlap of these disease states. Average overall cost per patient.

No, unfortunately, we cannot provide this information.

17. Define "elderly" and "disabled" in the scope of this project.

The definitions for "elderly" and "disabled" are those used for eligibility purposes, and can be found on the Community Services Offices' (CSO) website at: https://wws2.wa.gov/dshs/onlinecso/ .

18. The RFP stipulates that net savings will be on the "enrolled population" – are you expecting net savings on just those members who enroll specifically in our program or the total population?

The net savings will be measured only for those clients that are enrolled in the program.

19. What is the status of the voluntary enrollment amendment?

We plan to submit a State Plan Amendment requesting mandatory enrollment with an "opt-out" provision, prior to the January 1, 2002 contract start date. The State Plan process allows for retro-active approval of the amendment; we feel confident that our request will be approved.